SECTION 2

Medical Supplies

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1 MEDICAL SUPPLIES

A. Authority

The Utah State Department of Health, Division of Health Care Financing, in compliance with federal law defined in 42 CFR 440.70, provides a program under Home Health Services, to make medical supplies and durable medical equipment available to clients who are living at home and for certain circumstances to clients living in long term care centers.

B. Purpose

1. The Utah Medicaid Program covers medical supplies and equipment under four conditions: (1) The supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are listed on the Medical Supplies List included with this manual. Please note that changes in either policy or the Medical Supplies List are announced in Medicaid Information Bulletins. Medicaid coverage is stated in current policy and limited to items on the Medical Supplies List, as amended by Medicaid Information Bulletins.

2. Medical necessity does not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician's order must list each item required, a medical necessity, and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

3. The goal and purpose of the Medical Supplies Program is to provide services and/or supplies, ordered by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law, and the scope of service provided within the program. The objective of the program is to provide supplies for maximum reduction of physical disability and restore the client to his best functional level.

4. Medical supplies, durable medical equipment-prosthetic services are available to Categorically and Medically Needy eligible individuals who meet the severity of illness and intensity of service criteria.

5. Medical supplies are those items that are disposable or semi-disposable, are used for a client who is residing at home, and are used in conjunction with Home Health Agency nursing if necessary. However, it is not necessary to obtain the services of a Home Health Agency nurse in order to secure the needed supplies. It is necessary to reside at home. Examples of medical supplies are:
   a. elastic stockings
   b. ostomy supplies
   c. disposable or semi-disposable ostomy/urinary incontinency supplies are benefits under the program. Supplies should be limited to the most appropriate quantity for a one month usage. "Stockpiling" is prohibited.
   d. first aid supplies are limited to those used for post surgical need, decubitus treatment, and long term dressing. Routine minor first aid needs are not a benefit of the Medicaid program. Usual household remedies such as Band-Aids, hydrogen peroxide, etc., are not a benefit of the program.
   e. miscellaneous disposable supplies such as syringes, test-tape, and catheters are benefits under the program for patients who reside at home.

C. CHEC coverage

The Child Health Evaluation and Care (CHEC) Program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. Please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Services for specific information.

D. **Clients in Long Term Care and ICF-MR Facilities**

Disposable and semi-disposable medical supplies are **not** a benefit for patients residing in long term care facilities and ICF-MR facilities. These supplies MUST be furnished by the facility. These supplies include:

1. syringes;
2. ostomy supplies;
3. Irrigation equipment;
4. dressing;
5. catheters;
6. elastic stockings;
7. test tape;
8. I.V. set up.
9. Diapers

The following lists the ICF-MR facilities covered under this policy:
Bungalow, East Side, Hidden Hollow, Hillcrest, Lindon, Medallion Manor, Mesa Vista, Northside, Provo Care, Topham's Tiny Tots, West Jordan, West Side, West Horizon.

Covered items include:

1. Oxygen
2. Special beds and overlays and mattresses
3. Customized (Medicaid definition) and motorized wheelchairs
4. Prosthetic devices, such as artificial arms and legs, special braces for leg, arm, back, and neck.

E. **Durable Medical Equipment (DME)**

1. Durable medical equipment to be used by a patient who resides in a long term care facility continues to be the responsibility of the facility. This includes:
   a. wheelchairs;
   b. commodes;
   c. canes;
   d. walkers;
   e. traction equipment.

2. Durable medical equipment may not be replaced more often than every five years unless prior approved.

3. Rental of DME: Certain highly specialized equipment is so technical and costly to maintain that it is fiscally more responsible to furnish the equipment to a client on a permanent rental basis. This rental will include maintenance and back-up equipment if needed. This type of rental DME will have an RR modifier associated with the code.

4. Other rental DME may be capped and no more rental fees paid after 12 months. These codes will have the modifier LL associated with the code. DME that is capped and require maintenance and service may use the "ms" modifier once every six months, beginning six months after the rental has converted to a purchase and all rental charges have been billed for reimbursement for maintenance and service required to maintain the device. This may be billed using the HCPCs code and adding the "ms" modifier on the HCFA 1500 form. The reimbursement for the "ms" modifier will be equal to one monthly rental fee. A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use cease in order for a new 12-month rental period to begin.

   The maintenance and service fee is for maintenance and service on the DME as needed to keep the equipment operating properly and includes all supplies, service and maintenance which are routinely supplied when the item was being provided as a monthly rental.

5. Durable medical equipment such as wheelchairs, commodes, oxygen concentrators, and beds, are benefits of the program for clients residing at home. Canes and crutches are considered to be durable medical equipment and are supplied to assist the client with ambulation.

6. Limitations on DME: While the Division recognizes the desirability of many products and the sophistication of many modifications to durable medical equipment, it remains fiscally necessary to adhere to the guidelines established concerning these modifications. These guidelines stipulate that no item is reimbursable whose use is primarily for:
   a. hygiene;
   b. education;
   c. exercise;
   d. convenience;
   e. cosmetic purposes;
   f. comfort.

F. **Prosthetic Devices**

1. Prosthetic devices such as hearing aids and special appliances such as braces are a benefit of the Medicaid program. These devices comprise a group of items and are separate and distinct from the "Home Health Services" program and are available to persons residing in a long term care facility as well as for patients in their own home.

2. Provision of artificial limbs will be regulated by medical need. The prosthetic is reimbursable only every five years when medically necessary. Repairs and parts may be provided by medical need once yearly with prior approval. Certain exceptions may occur with growing children who have outgrown a prosthesis. Any exception to the established guideline will require prior authorization. Attachments and modifications will be available with prior approval only. Prudent buying and continued effectiveness are essential. Duplicative appliances, such as an artificial leg plus a wheelchair, will be reviewed carefully to determine necessity and/or duplication.

3. Although artificial eyes have been classified in some cases as cosmetic, the Division of Health Care Financing has adopted the guidelines promulgated by Medicare and will furnish the artificial eye to Medicaid clients via prior approval. Replacement will be made at five year intervals when medical need is verified.

4. Hearing aids are a benefit to the Medicaid client when medical need is established. The client must be referred to an audiologist who provides an audiometric examination which is submitted to the hearing aid provider. Refer to the Utah Medicaid Provider Manual for Audiology Services for criteria for coverage.

1 - 1 Credentials

To become a Medicaid provider for medical supplies and be eligible for reimbursement for medical supplies and equipment, providers must have a current business license, a tax I.D. number, a place of business and an inventory. Individuals providing services and supplies from an automobile or van with no home base may not become Medicaid providers.

1 - 2 Definitions

The following definitions apply to medical supplies and equipment covered by Medicaid.

Cassettes are prepackaged containers or envelopes of semi-disposable needles and tubing which provide a pathway for the total parenteral nutrition or intravenous medication to pass from container to vein.

Disposable means a medical supply or equipment that is intended for one-time use and not for re-use.

Durable medical equipment is medical equipment that can withstand use; is primarily used to serve a medical purpose; is appropriate for use in the home; and is generally not useful to a person in the absence of an illness or injury.

EN means enteral nutrition.

Enteral nutrition (EN) is nutrition by nasogastric, jejunostomy or gastrotomy tube into the stomach or intestines to supply total nutrition when a non-functioning gastrointestinal tract, temporary or permanent, is present due to pathology or structure.

I.V. means intravenous.

I.V. Medication is a sterile solution or a drug or an infusion injected into a vein for infection, pain, , hydration, blood factor replacement, or chemical or electrolyte replacement.

NDC means the National Drug Code.

National Drug Code means the unique eleven-digit number which identifies each approved drug product, dose, formation and strength.

Nutrients means those products with specific formulas used to supply total nutritional intake to the patient by gastrostomy, jejunostomy or nasogastric tube.

Orthotic device is a brace for neck, arm, leg, or leg which is not a part of another system.

Parenteral means any route used for infusing medication or nutrients other than the gastrointestinal tract.

Prosthetic device is a replacement, corrective, or supportive device prescribed to artificially replace a missing portion of the body; prevent or correct physical deformities or malfunction; or support a weak or deformed portion of the body.

TPN means total parenteral nutrition.

Total Parenteral Nutrition (TPN) is nutrition supplied directly into the blood stream by intravenous, subcutaneous, or mucosal infusion.

1 - 3 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed health care plan, such as a health maintenance organization (HMO), must receive all health care services, including medical supplies, through that plan. Refer to SECTION 1, Chapter 5, Verifying Eligibility, for information about how to verify a patient's enrollment in a plan. For more information about managed health care plans, refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization. All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. A list of HMOs with which Medicaid has a contract to provide health care services is available.

Specialized Medical Equipment for HMO Enrollees

When specialized medical equipment is ordered for a client enrolled in an HMO, and the client changes to another HMO before receiving the equipment, the HMO that ordered the equipment is responsible for payment.

The first HMO is responsible because it authorized the equipment, and that HMO's participating supplier ordered the equipment. Repeating the approval process at the newly selected HMO would cause a delay in the client receiving the equipment needed. Also, the supplier for the first HMO may not be a participating provider with the newly selected HMO, resulting in payment problems.

Home Health Services

When a client is enrolled in an HMO, the HMO is responsible to authorize home health services and reimburse the home health agency. Medical supplies used by the home health agency must be procured through the HMO medical supplier and billed to the HMO.

1 - 4 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan and *not* in the Restricted Program may receive services from any provider who accepts Medicaid. Refer to SECTION 1, Chapter 1 - 5, Restricted Program, for more information.

Coverage and the Medicaid prior authorization requirements apply **ONLY** to medical supplies and equipment to be provided to a Medicaid client assigned to a Primary Care Provider (instead of being enrolled in a managed care plan such as a health maintenance organization) or when the supplies/equipment are not included in the Medicaid contract with the managed care plan. Medicaid does NOT process prior authorization requests for supplies/equipment to be provided to a Medicaid client who is enrolled in a capitated managed care plan, and the supplies/equipment are included in a contract with a managed care plan. Providers requesting prior authorization for supplies/equipment for a client enrolled in a managed care plan will be referred to that plan.

Note: Medicaid staff make every effort to provide complete and accurate information on all inquiries. Because eligibility information as to what plan the patient must use is available to providers, a "fee for service" claim will not be paid even when information was given in error by Medicaid staff.

1 - 5 Legal References

42 Code of Federal Regulations, Part 440.70(b)(3), 440.120(c), 441.15.

Utah Department of Health Rule R455-12.

2 SCOPE OF SERVICE

The Medical Supplies List included with this manual contains the medical supplies and equipment covered by Medicaid, subject to the conditions stated and subject to changes adopted by state law, changes in policy or procedures, or changes announced in Medicaid Information Bulletins. The Medical Supplies List includes the HCPCS code and descriptor, or the State Medicaid 'Y' code and descriptor, any age limit, criteria for approval, whether prior authorization is required either by telephone or in writing, whether the item is covered when the patient resides in a long term care facility, and any limits on quantity.

This chapter and subsequent chapters provide additional information on the scope of service for medical supplies and equipment covered for Medicaid clients.

Quantity Limitations

Exceeding quantities and limitations as stated in this manual requires prior authorization. Certain medical supply codes are open only to clients who are on one of the waivered programs, such as the technology dependent waiver (the Travis C Waiver is one of these). Other codes will have different limits allowed for those under a waiver. To determine if a client is on a waiver please call Medicaid Customer Service, 538-6155 or 1-800-662-9651. If it is medically necessary to exceed the limits listed in the Manual – including the extra limits allowed to waivered clients, a prior authorization must be obtained.

Categories of medical supplies and equipment on the Medical Supplies List include the following:

1. **First Aid Supplies**

   First aid supplies are limited to those used for post surgical need, accidents, decubitus treatment, and long term dressings. Individual supplies must be billed as separate items. First aid supply kits are not covered. Please note that it is generally not cost effective for a medical supplier to bill Medicaid for one roll of tape.

   A. **Diapers**

   Diapers are covered *for disabled children and adults* only. **Exceptions:** They are not covered for normal infant use nor for adult incontinence not related to with a disability. They are not covered for residents of LTC and ICF-MR facilities. Only generic items are covered, not name brands, such as Attends, Depends, etc. Reimbursement is based on the least expensive disposable diaper available. The amount is limited to a one-month supply.

   B. **Disposable Supplies**

   Disposable supplies are non-reusable items. Disposable supplies include but are not limited to syringes, surgical stockings, ostomy supplies, catheters, underpads and a new group of disposable dressings for treatment of decubitus ulcers and burns.

2. **Surgical Stockings**

3. **Urinary Catheters**

4. **Ostomy Supplies**

5. **Syringes**

6. **Miscellaneous Supplies**

7. **Enteral, Parenteral Nutrition**. Refer to Chapter 2 - 2, Parenteral and Enteral Nutrition Therapy.

8. **Nutrients**. Refer to Chapter 2 - 1, Nutritional Products.

9. **I. V. Supplies**. Refer to Chapter 2 - 3, I.V. Therapy.

10. **Pumps**. Refer to Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps.

11. **Ambulation Devices**

12. **Bathroom Equipment**

13. **Decubitus Care**. Refer to Chapter 2 - 5, Decubitus Care: Water or Air Fluidation Beds.

14. **Hospital Beds and Accessories**. Refer to Chapter 2 - 6, Hospital Beds.

15. **Oxygen and Related Respiratory Equipment**. Refer to Chapter 2 - 7, Oxygen and Related Respiratory Equipment.

16. **Additional Oxygen Related Supplies**. Refer to Chapter 2 - 7, Oxygen and Related Respiratory Equipment.

17. **Humidifiers and Nebulizers**

18. **Suction Pumps and Room Vaporizers**

19. **Monitoring Equipment**. Refer to Chapter 2 - 8, Monitoring Equipment.

20. **Patient Lifts and Traction Equipment**

21. **Wheelchairs and Wheelchair Accessories**. Refer to Chapter 2 - 9, Wheelchairs.

22. **Wheelchair Replacement Supplies**. Refer to Chapter 2 - 9, Wheelchairs.

23. **Repair or non-routine service**. Refer to Chapter 7, Repairs and Replacement.

24. **Durable Medical Equipment, Not Classified**

25. **Pneumatic Compressor and Appliances**

26. **Cervical collar**

27. **Spinal, Thoracic Lumbar Sacral Braces and Orthoses**

28. **Spinal, Lumbar Sacral Braces and Orthoses**

29. **Spinal, Sacroiliac Braces and Orthoses**

30. **Scoliosis, Cervical Thoracic Lumbar Braces and Orthoses**

31. **Lower Limb: Hip, Knee, Ankle Braces and Orthoses**

32. **Additions to Lower Extremity: Orthoses**

33. **Foot Orthopedics: Shoes and Modifications**. Shoes and shoe modifications and repairs are NOT covered, with the following exceptions:

    A. Shoes may be allowed with telephone prior authorization for three circumstances:

        1. When shoe is attached to and part of a brace;
        2. When shoe is especially constructed to provide for a totally or partially missing foot;
        3. When shoe is attached to and specially fitted to a prosthesis.

    B. Shoe modifications may be made externally to a shoe owned by the patient. Modification may be made to elevate a total shoe or provide elevation to part of a shoe.

34. **Upper Limb Orthosis**

35. **Orthotic Repairs**

36. **Prosthetics, Lower Limb**

37. **Upper Limb: Medical Supplies**

38. **Repair Prosthetic Device**

39. **Breast Prosthetics**

40. **Prosthetic Sock**

41. **Eye Prosthesis**

42. **Hearing Aids and Repairs**. For complete information about coverage of hearing aids and assistive listening devices, refer to the Utah Medicaid Provider for Audiology Services.

2 - 1 Nutritional Products

All nutritional products require a physician's order or prescription. To be approved, the enteral product must be given by gastrostomy, jejunostomy or nasogastric tube (NG, NJ, GT, JT). Enteral products are prescribed by the physician with the specific product best suited to the patient identified.

Parenteral products are identified by protein content. The physician's order must specify the kilo calories necessary per day. Parenteral infusions are identified and reimbursed per daily Kcal requirements. Other additives are identified in Chapter 2 - 3, I.V. Therapy.

Enteral and parenteral nutritional products are covered only as total nutrition when the client has a totally missing or damaged part of the gastric system. Total nutrition is not available due to psychological problems or failure to thrive.

Limitations

1. Baby foods, such as Similac, Enfamil or Mull-Soy, are breast milk substitutes and are not covered by Medicaid. These are considered foods.

2. Nutritional supplements are NOT covered for Medicaid clients. Supplements are considered food, not a medical supply. Supplements are available through benevolent organizations, such as food banks, churches, civic groups, and government programs, such as the Food Stamp Program, the Women, Infants and Children (WIC) program, and the Commodities Program. However, special situations may exist for children, and the CHEC program (Child Health Evaluation and Care Program for Medicaid clients from birth through age twenty) may allow payment for a non-covered service. Refer to the Utah Medicaid Provider for Child Health Evaluation and Care (CHEC) Program Services for specific information

3. **Resident of a Long Term Care Facility**: Parenteral solutions and total enteral therapy may be covered for patients residing in a long term care facility.

   A. Covered supplies include:
      (1) Parenteral solutions.
      (2) A monthly parenteral nutrition administration kit which includes all catheters, pump filters, tubing, connectors, and syringes relating to the parenteral infusions.
      (3) Enteral solution for total enteral therapy given by tube.

   B. Long term care facilities and home health agencies must have personnel trained to place and care for TPN and EN naso-gastric gastrostomy or jejunostomy tubes.

   C. Nutrition and nutritional supplements are included in the per diem paid by Medicaid under contract with a long term care facility and are therefore not reimbursable for its patients. For more information about medical supplies covered under the Medicaid contract, refer to Chapter 5, Supplies for Patients in A Long Term Care Facility.

2 - 2 Parenteral and Enteral Nutrition Therapy

Eligible Medicaid clients with chronic illnesses, trauma, or terminal disease who are able to live at home or in a long term care facility, but who cannot be sustained with oral feeding and, therefore, rely on total parenteral nutrition (TPN) or enteral nutrition (EN) to sustain life are covered under this program.

The I.V. therapy program provides medications, solutions, blood factors, chemicals, or nutrients by injection or infusion for eligible Medicaid clients who reside at home or, in some cases, in a long term care facility.

A. Authority

The provision of service by Home Health is authorized in the 42 CFR 440.70 and 441.15, and The Omnibus Reconciliation Act (OBRA) of 1987, PL 100-203, Section B.

B. Purpose

1. The purpose of the TPN program is to provide total parenteral nutrition or enteral nutrition to sustain life and provide an improved quality of life for a short or long-term period.
2. The objective of the I.V. therapy program is to sustain life, reduce pain, reduce or eliminate infection, provide fluids, replace or provide necessary chemicals to maintain electrolyte balance, or provide blood products.

C. Definitions

Refer to Chapter 1 - 2, Definitions.

D. Eligibility Requirements/Coverage

Medicaid services are available for all eligible categorically and medically needy individuals.

E. Program Access

The services are available as detailed in this manual. All parenteral nutrition therapy, enteral nutrition and I.V. therapy require a physician's order or prescription. Three groups of persons are eligible for TPN and EN:

1. Persons with a missing digestive organ.
2. Persons with a long-term or permanently non-functioning gastro-intestinal tract.
3. Persons with a short-term non-functioning gastro-intestinal tract, such as may occur following a surgical procedure.

F. Service Coverage

1. Home-based Patients
    a. TPN, EN, and I.V. therapy are Medicaid benefits for patients residing at home, subject to the prior authorization requirements.
    b. Any Home Health Agency may be directed by physician's order to provide service for the patient using the Home Health policy guidelines. Intravenous catheters to begin an I.V. infusion may be placed by a Home Health Agency nurse who has been trained for I.V. catheter placement, a physician, or a physicians' assistant whose training and protocols allow for this service.
    c. Medications are available for I.V. therapy or nasogastric therapy through the Pharmacy Program.
    d. Nutritients and metabolics are available through the Medical Supplies program.
    e. Medical supplies and equipment required for I.V., EN, or TPN therapy may be supplied by a medical supplies provider or a pharmacy. Heparin flush and heparin may be provided and reimbursement made to the pharmacy. Nutrient container bags will not be reimbursed if a monthly enteral feeding supply kit, which contains all ancillary supplies is requested by the physician and provided to the patient.

2. Resident of a Long Term Care Facility
   a. Parenteral solutions and I.V. therapy provided by infusion or enteral therapy are Medicaid benefits for residents of a long term care facility, subject to the prior authorization requirements found below.
   b. The facility must have nurses who are trained to place and care for the TPN or I.V. catheter.
   c. A pharmacy in the facility or in the community may provide the following:
      (1) Parenteral solutions.
      (2) A monthly parenteral nutrition administration kit which includes all catheters, pump filters, tubing, connectors and syringes relating to the parenteral infusions.
      (3) Enteral solutions for total enteral therapy.
      (4) I.V. medications, blood factors, and solutions.
      (5) Enteral administration kits are a benefit. Enteral bags are not a benefit in addition to the kit.
      (6) Heparin flush and heparin.
   d. Equipment such as I.V. poles, disposable swabs, antiseptic solutions and dressings for the catheter are not reimbursable by Medicaid for residents of a long term care facility.

G. **Metabolic Nutritional Supplements**

Metabolic nutrition may by covered by Medicaid if there is a documented failure to oxidize an amino acid resulting from a diagnosed disease for children under age 21. Enteral and metabolic nutrients requested by WIC require a written prior authorization. A telephone request may be made for all other prescriptions. The Medical Supplies List has specific products and criteria.

The physician must order the product by prescription which must include:
1. The product name.
2. The prescribed intake amount, e.g. grams, ml etc., and
3. The daily frequency of ingestion, or
4. The total daily prescribed amount, e.g. grams, ml etc.
5. The duration or period of time the product is to be used, e.g. days, weeks, months, etc.

H. **I.V. Therapy**

Intravenous therapy and treatment, which may include injections or infusions, are reimbursable to providers. In addition to TPN or EN therapy, I.V. therapy may include:
1. pain-medication therapy;
2. antibiotics and antimicrobials;
3. fluids such as glucose and fluid replacement;
4. electrolytes;
5. blood products;
6. I.V. supply kit for patients residing at home;
7. extension tubing set for peripheral or midline catheter; or
8. solution used to cleanse or irrigate the catheter for which an NDC code exists.

The purpose of the Total Parenteral Nutrition (TPN) and Enteral Nutrition (EN) therapy programs is to provide parenteral or enteral nutrition to sustain life and to improve the quality of life. There must be a reasonable medical expectation that an improved quality of life will ensue from the parenteral or enteral therapy.

Pharmaceuticals, injectables and diluents are billed to Medicaid using NDC numbers, typically through the Pharmacy Point-of-Sale electronic billing system. These are not billable as medical supplies. Medical supplies can not be billed using the Point-of-Sale electronic billing, but must be billed on a HCFA 1500 form after necessary preauthorizations.

Nutritional products may be covered when a Medicaid client (1) has chronic illnesses, trauma or terminal disease that renders the gastric system, mouth, stomach, or intestines non-functional, and (2) cannot be sustained with oral feeding. Nutritional products are available as total parenteral nutrition (TPN) or total enteral nutrition (EN).

Eligibility for TPN or EN Therapy

1. To qualify for TPN or EN, a Medicaid client must meet at least **one** of the three conditions below:

    a Have a missing or damaged part of the digestive system which does not allow food to pass through the mouth, stomach and/or intestines.

    b. Have a long-term or permanently non-functioning gastrointestinal tract. Non-functioning means severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition. (Transmittal No. 178, Department of Health and Human Services.) Daily <u>parenteral</u> nutrition may be medically necessary for this condition.

    c. Have a short-term non-functioning gastrointestinal tract, such as may occur following a surgical procedure. Daily <u>enteral</u> nutrition may be medically necessary for this condition.

    Enteral nutrition concerns product and mode of transfer of the product. The transfer can be through a tube directly into the stomach (gastrostomy), a tube into the intestine (jejunostomy) or a tube through the nose into the stomach (nasal gastric delivery). There are many products that may be used in these delivery systems. The product is chosen by the physician to best suit the needs of the patient by formulation. Refer to the <u>Medical Supplies List</u> for the codes which specifically identify the products intended in each category of transfer.

2. **Home-based patient**: TPN and EN therapy may be covered for patients residing at home.

    a. Medical supplies and equipment required for TPN and EN therapy may be supplied by either a medical supplier or a pharmacy.

    b. Enteral nutrition (EN) is expected to be given by nasogastric, jejunostomy or gastrostomy tubes.

    c. EN therapy that involves an infusion pump must be supported with documentation that gravity feeding is not satisfactory due to either aspiration, diarrhea or dumping syndrome. Payment will be based upon the amount established for the simplest model that meets the medical needs of the patient as established by medical documentation. (See #220. 2B, Department of Health and Human Services Transmittal No. 178.)

    d. Nutrient container bags will not be reimbursed if a monthly enteral feeding supply kit (which contains all ancillary supplies) is requested by the physician and provided to the patient.

e. A daily administration supply kit containing all supplies is covered only for patients residing at home.

(1) A daily parenteral nutrition administration kit which contains all catheters, pump filters, tubing, syringes, connectors and cassettes may be supplied.

(2) Either an enteral administration kit per day is allowable *or* an enteral nutrition bag, but not both. Enteral feeding supply kits contain all ancillary supplies such as cassettes and nutrient container bags. Therefore, nutrient container bags are not a benefit when the enteral feeding supply kit is being used.

f. The simplest form of feeding, by syringe, is preferred. Gravity flow is preferable to the use of a pump. When a pump is medically necessary, refer to Chapter 2 - 4, Enteral, Parenteral and I.V. Therapy Pumps.

Prior Authorization Requirements for Parenteral and Nutritional Therapy

1. Nutrients and supplies

a. All parenteral and enteral nutrition therapy requires a physician's order or prescription. The order must include the name of the product, dose and frequency or total amount per day.

b. Enteral nutrition is available only for clients requiring total nutrition through a tube. Nutrition taken P.O. is not covered.

c. All changes require prior authorization and will be effective on the date of the request call to the Prior Authorization Unit.

d. Each provider -- the home health agency and the pharmacy or medical supplier -- must make separate requests for prior authorization for their respective services, nutrients and supplies.

e. All parenteral and enteral solutions and equipment require prior approval. There must be a reasonable medical expectation that an improved quality of life will ensue from the parenteral, enteral or I.V. therapy.

2. Prior Authorization

a. The licensed pharmacy must request a prior approval from Medicaid for the nutrients and supplies. The physician's prescription must be on file when requesting prior approval.

b. The attending physician must justify the use of a pump for metered dosage, continuous infusion, extremely small doses which cannot be measured accurately without a pump, or other special medical need. This medical need determination must establish that syringe feeding or gravity feeding is not satisfactory due to aspiration, diarrhea, or dumping syndrome or other unique medical manifestations. The simplest form of feeding, by syringe, is preferred. Gravity flow is preferable over the use of a pump. Diagnosis and applicable history from the physician must be included to support the need for a pump. A kangaroo-style pump is preferable to a more sophisticated pump, unless prior approval for the more sophisticated pump is obtained.

c. The home health agency and the pharmacy must make separate prior approval requests for their respective services and supplies.

d. I.V. products such as antibiotics, blood factors, electrolyte products, fluids, or glucose supplied by the pharmacy which require prior approval are identified in the pharmacy program, at R414-10.

e. Intravenous catheters are reimbursable to a pharmacy or a medical supplier only with prior authorization.

f. Gravity flow supplies and equipment are exempt from prior authorization requirements.

g. There must be a new prior authorization every six months to renew the type of feeding or therapy in use for home health patients. Extended use of TPN or EN without home health intervention may be approved for a longer period of time. When a patient reaches the established goal for enteral or parenteral feeding, additional service will not be authorized unless it is a medical requirement.

2 - 3 I.V. Therapy

The purpose of the intravenous (I.V.) therapy program is to sustain life, reduce or eliminate infections, replace or provide necessary chemicals to maintain electrolyte balance, provide blood products or chemotherapeutics. I.V. therapy and treatment, which may include injections or infusions, may be covered when a Medicaid client cannot use oral medications and therefore must rely on I.V. therapy. I.V. products (such as medications, antibiotics, blood factors, electrolyte products, fluids, glucose, diluents, injectable medications, and solutions) are covered under the Pharmacy Program; some products require prior authorization. Pharmaceuticals, injectables and diluents are billed to Medicaid using NDC numbers, typically through the Pharmacy Point-of-Sale electronic billing system. These are not billable as medical supplies. (Refer to the Utah Medicaid Provider Manual for Pharmacy Services.)

I.V. therapy includes:

1. Pain medications
2. Antibiotics, antibacterials, and antimicrobials
3. Fluid replacement and fluids such as glucose
4. Electrolytes
5. Blood products and factors
6. Heparin flush and heparin

There is no reimbursement for "preparing" I.V. supplies, such as filling syringes.

Long term care facilities and home health agencies must have personnel trained to place and care for I.V. catheters.

Intravenous catheters are reimbursable to either a pharmacy or medical supplier with prior authorization through the Medical Supplies program.

Limitations for TPN or EN Therapy.

Limitations for TPN or EN therapy are as follows:

1. Cassettes are supplied with the parenteral administration kit, and the provider may bill for the parenteral administration kit only once monthly.

2. Enteral nutrients, I.V. diluents, injectable medications, and solutions are available as allowed in the pharmacy program with the limitations stipulated therein.

3. Baby foods, such as Similac, Enfamil or Mull-Soy, are breast milk substitutes, and thus are not Medicaid benefits.

4. Kits, bags and pumps are not benefits with nutritional supplements.

5. A monthly supply kit containing all supplies except the catheter is a Medicaid benefit only for patients residing at home. Prior authorization is required.

2 - 4 Enteral, Parenteral and I.V. Therapy Pumps

ALL pumps require prior authorization. The Medical Supplies List has four categories of pumps identified. Criteria for each type are listed for each supply code for each pump and bag or cassette. Below is a summary of the four categories.

1. Totally disposable unit - non-electronic: Pumps include disposable infusion pumps, I.V. flow control devices, and syringe replacements for the I.V. flow control device. Totally disposable pumps have very limited use as determined by efficiency and/or cost. For example, a Utah Medicaid client leaving the state to establish residency in another state may be more efficiently treated in route with totally disposable, pre filled pumps. Each situation is reviewed by Prior Authorization staff for appropriateness.

2. Insulin pump - insulin specific pump, non-implanted: Includes external ambulatory infusion pump, infusion set for external insulin pump, and syringe with needle for external insulin pump.

3. Stationary pump for patients who are partially bed bound. Includes parenteral and enteral pumps and supply kits and I.V. infusion pumps.

4. Semi-stationary or ambulatory pump for specific product infusion: Pumps can be electronic or mechanical (CADD, MANX, sidekick, Band-It Syringe Driver, etc.). Includes containers for 50 ml. to 100 ml. delivery and bags or containers for 250 ml. to 400 ml. delivery. Many of these pumps, such as CADD or MANX, are for extended delivery (antibiotics, for example) and do not require a bag or cassette daily.

Prior Authorization for Pumps

TPN or I.V. therapy requiring a pump must be accompanied by sufficient evidence that pump therapy is necessary. Diagnosis and applicable history from the physician must be included to support the need for a pump. The physician must justify the use of a pump for metered dosage, continuous infusion, extremely small doses which cannot be measured accurately without a pump, or other special medical need. This determination of medical need must establish that syringe feeding or gravity feeding is not satisfactory due to aspiration, diarrhea or dumping syndrome or other unique manifestations. A kangaroo-style pump is preferable to a more sophisticated pump.

I.V. pumps are not covered for rehydration.

Payment for pumps will be based upon the amount established for the simplest model that meets the medical needs of the patient as established by medical documentation and the days of use. (Number 220.2B, Department of Health and Human Service Transmittal Number 178) Reimbursement will be based per day of use.

Refer to the Medical Supplies List for details concerning pumps and pump supplies.

Reimbursement

1. Medicaid benefits include reimbursement to the Home Health Agency by procedure code for approved nursing care services for patients using TPN, EN, or I.V. therapy.

2. Medicaid benefits also include reimbursement to the pharmacy for approved parenteral or enteral supplies, nutrients and medications. There is no additional reimbursement to the pharmacist for preparing the medication, such as filling syringes, mixing solutions, or adding drugs to an infusion solution. Pharmacists bill Medicaid using National Drug Codes.

3. Heparin for flushing the infusion catheter is billed on a pharmacy claim form, using the National Drug Code.

4. Reimbursement will be made for an enteral supply kit only if total enteral feeding is required, and the patient is at home.

5. Reimbursement for Medicare and Medicaid dual eligibility clients is available as follows:
   a. TPN and EN systems, and related supplies, equipment and nutrients, are covered by Medicare as prosthetic devices if they replace normal nutritional function of the esophagus, stomach, or bowel.
   b. Billing procedures for dual eligibility patients are described in Chapter 6, Prior Authorization. Those procedures must be followed in order to assure reimbursement.

Procedure Codes

Procedure codes for I.V. therapy, enteral or parenteral services are in the Medical Supplies List and the Utah Medicaid Provider Manual for Home Health Services. Providers must use these procedure codes when billing.

2 - 5 Decubitus Care: Beds, Pads, Mattresses, and Overlays

The provision of decubitus care products such as beds, pads, mattresses, and overlays is not a substitute for extensive and diligent nursing care. Rather, the provision of these products is to assist the establishment of a comprehensive program for treating and limiting decubitus ulcers.

Decubitus care products are for Medicaid clients who have stage II III, or IV decubitus ulcers of the trunk only which have not responded to prolonged intensive nursing care, including dressing applications, and proper nutrition. Treatment for pressure ulcers on the head, heel or extremities is not covered. Decubitus care includes burns and post surgical skin grafts. Equipment and supplies are for use in an long term care facility or home. The intensive nursing must be documented, including nutritional intake measurements, hydration, and laboratory tests.

Decubitus care is designed to provide a **pro active approach** to decubitus treatment. **Facilities and care givers should work hand in hand** to prevent ulcers before they get to a stage that is more difficult to control. This approach should assist the prevention of stage II ulcers from progressing to stage III. If progression to stage III or IV occurs, an investigation from Medicaid Long Term Care Certification team will be recommended.

Dressings

The use of dressings designed for decubitus ulcers is encouraged. Most dressings do not require prior authorization and are available to long term care patients and patients residing at home.

LONG TERM CARE FACILITIES

A. Prior Authorization is required for beds, pads, mattresses and overlays for residents of long term care facilities. The request must include the following:

A statement of the presence, location and size of stage II, III, or IV pressure ulcer.

1. Documentation which shows
   a. Patient has been turned and repositioned every 2 hours at minimum;
   b. Adequate nutritional status and hydration with intake measurements, including supplements and diet sheets;
   c. Albumin within normal limits with appropriate lab tests. If albumin is abnormal, describe the measures taken to address adequate protein intake;
   d. Weight reduction diet if needed;
   e. Current or most recent MDS sheet submitted;
   f. Inability and/or unsuccessful attempts to position off the area;
   g. Location and picture of ulcers;
   h. Physician's order for DME;
   i. Documentation of limited mobility (22 hours or more of confinement to bed.);
   j. Appropriate dressings/debridement;
   k. Nurse's notes and information showing patient would cooperate with treatment.

2. Please submit all documentation in a single packet for prior authorization review.

B. Mattresses And/or Overlays

In the event that intensive nursing, measured nutrition, debridement and physician consultation are documented, and these interventions have not been adequate to reduce the pressure ulcer, the use of mattresses and/or overlays may be authorized. In addition to the mattresses and overlays described in the Medical Supplies List, the equipment listed below **requires prior authorization**.

E0277LR, Powered pressure-reducing air mattress
E0193LR, Powered air flotation bed (low air loss)
E0373, Advanced pressure relieving mattress (purchase only)

Code E0373 is a mattress which can be purchased for a specific patient to used only by the owner/patient to reduce a now intractable or multi-stage III ulcer and prevent further, repeated tissue breakdown.

An extended care nurse, home health nurse or physician must determine the specific product appropriate for the client, but only a physician may order the bed, mattress, pad, or overlay.

A. Stage II pressure ulcers, Long Term Care Facility

After aggressive nursing intervention, as described in item B above, a pressure reducing mattress or overlay, such as code E0277, may be authorized for maximum of 14 days rental.

B. Stage III pressure ulcers, Long Term Care Facility

After aggressive nursing care, as described in item B above, and the patient has tissue that is still breaking down, the following additional criteria will apply:

1. Requests for services for new admits to a facility from home or hospital must be made within 2 weeks of the admission.
2. New admits from other facilities must under go two months of aggressive nursing care to resolve the pressure ulcer and fulfil the documentation requirements before requesting a mattress or overlay.
3. Current MDS sheet submitted.
4. Physician's orders and plan of care.
5. Documentation of location and size of Stage III pressure ulcer.
6. Code E0373, advanced pressure relieving mattress, may be authorized for purchase for the patient. (This mattress becomes the property of the patient and must be transferred with the patient.)

C. Stage IV pressure ulcers, Long Term Care Facility

After aggressive nursing care as indicated in the above documentation, and the patient has tissue that is still breaking down and progressed to a stage IV, the following additional criteria apply:

1. Only available for new admits to a facility from home or hospital. Transfers from long term care facilities are not covered. If the facility allowed a stage IV to occur under their care they are responsible for the beds, mattresses and overlays.
2. The request must be made within 2 weeks of the admission.
3. Current MDS sheet submitted.
4. A physician's order and prescription for plan of care which should include a flap procedure or the reason a flap procedure is contraindicated.
5. Code E0373, advanced pressure relieving mattress, may be authorized for purchase for the patient.

PATIENTS RESIDING AT HOME

Coverage for decubitus care does **not** include hospital beds used in the home for bed bound patients nor mattresses for those hospital beds. These are covered for other conditions for non-mobile clients in other sections of the Medicaid Medical Supplies Manual. The client must provide a bed frame and foundation when a mattress is provided for use in the home.

Most patients residing at home will have Medicare coverage, and providers must bill Medicare first. If a patient is **not** covered under Medicare, the following guidelines apply.

A. Prior Authorization is required for beds, pads, mattresses, and overlays and must include the following:

1. Treating physician's orders.
2. Statement of inability to position off area.
3. History of appropriate dressings/debridement.
4. Information showing patient would cooperate with treatment.
5. Statement indicating there is adequate nutrition to maintain skin integrity.

B. Stage II pressure ulcers, patient resides at home

1. Home Health nursing must be involved in the patient's care and provide training for appropriate treatment for decubitus ulcers and the use of the overlay mattress, if approved.
2. An overlay mattress such as, E0277, may be authorized for 14 days for stage II pressure ulcers after documentation by home care nursing notes:
   a. Patient turning every two hours;
   b. Adequate nutrition and hydration;
   c. Need for additional services beyond routine wound care.

C. Stage III pressure ulcers, patient resides at home

After nursing care provided for stage II pressure ulcers (item B above), and the patient has tissue that breaks down to a stage III, the following additional criteria apply.

1. Home health nursing must be involved with the patient's care.
2. The use of decubitus dressings /debridement and respositioning attempts must be documented.
3. Nutrition and hydration intake documented.
4. If the ulcer is progressing, consultation between the home health nurse and the physician should consider alternate placement in a long term care facility.
5. Code E0373, advanced pressure relieving mattress, may be authorized for purchase for the patient. (If Medicaid purchased a mattress for use in the home, and the patient is transferred to a long term care facility, the mattress must be transferred for use in the care facility.)
6. Stage IV pressure ulcers should be referred by the physician and treated in a long term care facility.

2 - 6 Hospital Beds

All hospital beds require prior authorization. Criteria are that the patient is bed confined and resides at home, not in an institution, care facility, etc. The term "bed confined" means that the patient's medical condition is of such severity that essentially the patient is confined to bed -- although not necessarily 100 percent of the time. Typically, the bed confinement is 80 percent of the time (19 - 20 hours a day).

The patient's condition must necessitate either (1) positioning of the body (especially the head, chest, legs, and feet) in a way which would not be feasible in an ordinary bed, or (2) attachments to the bed which could not be affixed to an ordinary bed.

1. A standard hospital bed is:
   a. Of a design and construction equal to the standard which is common within the industry, consisting of a modified catch spring assembly, mattress and bed ends with casters and manually operated foot end cranks which permit independent adjustment of the elevation of the head and knee sections;
   b. Capable of accommodating a standard trapeze bar when attached to the head end;
   c. Equipped with I.V. sockets;
   d. Capable of supporting an overhead frame and other accessories that utilize I.V. holes for mounting purposes; and
   e. Equipped to accommodate side rails, if required by the patient's condition.

2. Side rails on hospital beds are not considered a standard feature of hospital beds and are not covered under the program, except when specifically prescribed as medically necessary and specifically included in the procedure code description.

3. Variable height beds are not a benefit of the Medicaid program.

4. Electric beds are not a benefit of Medicaid.

5. Air or water fluidation beds are a Medicaid benefit under the specific guidelines on the Medical Supplies List. The beds require prior approval and may be requested for clients who reside at home or in a long term care facility.

2 - 7 Oxygen and Related Respiratory Equipment

Oxygen is a benefit of the Medicaid program. However, for a patients who resides in a long term care facility, only the oxygen is reimbursable; all equipment is the responsibility of the facility. Oxygen orders or prescriptions from the physician must be attached to the Prior Authorization Request and contain liter flow and hours per day usage. ONE OXYGEN SYSTEM ONLY will be provided, except under specific circumstances.

ALL OXYGEN SYSTEMS WILL BE REPLACED BY A CONCENTRATOR WHEN THEY ARE (1) more economical and (2) more appropriate.

All oxygen requires prior authorization. Criteria for oxygen include:

1. Diagnosis indicating that the client's ability to breathe is severely impaired.

2. Physician order indicating liter flow, duration of therapy, frequency (hours per day) and the statement which indicates that oxygen is necessary.

3. If oxygen is required for exercise, the physician must specify type of exercise, outdoors or indoors, length of time, etc. Clinical notes must document the exercise program.

Oxygen Concentrators

Oxygen concentrator systems require prior authorization. Unless otherwise justified by the physician in the request for prior authorization, all patients will be approved for an oxygen concentrator system, rather than a gaseous or liquid system. Each concentrator placement includes one emergency tank to be used only for power failure. Concentrators are available only through the supplier who contracts with Medicaid.

Oxygen concentrators are required for infants using 1 liter per minute or more. A concentrator is also required for part-time use. Patients simultaneously using other equipment will be considered for approval of gaseous or liquid oxygen on a case by case basis.

Gaseous Oxygen System

A gaseous system is approved only in two circumstances:

1. Situations in which electrical power to run the concentrator is not available. These cases are unique and require case by case evaluation. Occasionally, a power source is required, such as a generator, in specific situations.

2. When other associated equipment requires a saturation percentage higher than the concentrator can deliver or the required liter flow is higher than the concentrator's delivery.

Portable Gaseous System

Portable oxygen may only be provided for medical appointments or exercise prescribed by a physician. Portable oxygen for recreational or daily living activities is not a Medicaid benefit. Approval for a portable gaseous system will be based on documented medical necessity with a physician's written prescription that includes the liter flow per minute, the length of time of expected use, and, if the patient is in a long term care facility, whether he must exercise away from the original oxygen source (e.g. outside). A portable gaseous system will not be approved if the patient requires oxygen only intermittently or part-time. When prior authorization is given, portable oxygen need not be ordered from or supplied by the oxygen concentrator contractor.

If the existing oxygen supply cannot be utilized or the exercise is out of doors, patient age, prescribed liter flow, number of needed medical visits, and prescribed exercise regimen are used to determine the maximum number of portable oxygen tanks approved. Refer to the Medical Supplies List for details.

Liquid Oxygen Systems

The request for prior authorization must document in detail the need for the liquid and specify the equipment required. Liquid oxygen is approved only when (1) multiple equipment is being used by the patient in a series, such as compressors, ventilators etc.; (2) a specific medical need has been established; and (3) gaseous oxygen will not provide the liter flow per minutes or the percent concentration.

Liquid systems for mobility of the patient outside the home, such as a "stroller," are **not** a Medicaid benefit. Other portable gas systems may be used to transport the patient to the physician's office.

Liquid oxygen is billed in 10 pound increments.

Code E0439LR is used for per month for a stationary liquid oxygen system PLUS 10 pounds of liquid oxygen. If more than 10 pounds of liquid oxygen is used per month, refer to the following: Use code E0442 for additional liquid oxygen, 10 pounds each. If 20 pounds oxygen is used after the original 10 pounds requested, bill code E0442 with two units. Preauthorization is given by units; one unit equals 10 pounds.

Two oxygen systems with attachments are not a Medicaid benefit, since two systems cannot be used simultaneously.

Ventilators

Home care of a patient requiring a ventilator to sustain life is encouraged by Medicaid if the patient's needs can be met adequately and safely, and if the service requested is cost-effective within Medicaid policy limitations.

2 - 8 Monitoring Equipment

Monitoring equipment is not covered for a resident of a long term care facility, skilled nursing facility or intermediate care nursing facility.

An automatic blood pressure monitor requires written prior authorization. (e.g., Dynamap or continuous pressure monitoring devices.) Digital blood pressure monitors are **not** covered.

Glucose monitors are provided free of charge by the manufacturer/distributor and are not covered by Medicaid. However, a blood glucose monitor with special features (for example, voice synthesizers, automatic timer, etc.) may be provided with written prior authorization.

Infant apnea/bradycardia monitors are supplied under contract and require prior authorization by Medicaid.

Requirements for oxygen monitoring equipment are in the Medical Supplies List.

2 - 9 Wheelchairs

Wheelchairs are a Medicaid benefit when the client's condition is such that, without the equipment, bed confinement (or chair confinement) would be required.

Reimbursement is limited to the lowest commonly available charge for a standard wheelchair. Other chairs must be specifically prescribed and documentation provided concerning medical necessity.

Medicaid has redefined the categories for wheelchairs to the Medicare categories and definitions: Standard, Customized, and Motorized. The term "specialized" is no longer used by Medicaid as a definition or category.

The Medical Supplies List included with this manual contains a list of wheelchairs, wheelchair accessories and replacement supplies. All wheelchairs, accessories, attachments, replacement supplies and repairs require prior authorization. The list indicates whether the prior authorization must be in writing or may be obtained by telephone. Generally, telephone prior authorization is allowed only for rental wheelchairs. The criteria for standard, customized, and motorized wheelchairs and procedures to obtain authorization from Medicaid are described in this chapter.

Table of contents for wheelchair-related sub-sections in Chapter 2 - 9

A. Wheelchairs Purchased by Medicaid

Medicaid will pay for one wheelchair which is the most cost effective that satisfies the medical needs of the Medicaid client. Wheelchairs purchased by Medicaid for a client belong to that client. Repairs to a wheelchair owned by a client are covered by Medicaid with a physician's order and a determination of cost-effectiveness.

A standard manual second wheelchair may be allowed only for clients whose aggregated weight of client and power wheelchair exceeds the limitations of the power lifts on transportation vehicles. This is provided to allow clients to be transported in a manual wheelchair to Medicaid covered medical appointment without exceeding the lift capacity of the transportation vehicle. The second wheelchair will be appropriately sized to accommodate the size and weight of the recipient.

A standard manual second wheelchair may be allowed only for clients whose aggregated weight of client and power wheelchair exceeds the limitations of the power lifts on transportation vehicles. This is provided to allow clients to be transported in a manual wheelchair to Medicaid covered medical appointment without exceeding the lift capacity of the transportation vehicle. The second wheelchair will be appropriately sized to accommodate the size and weight of the recipient. This is the only circumstance wherein a second wheelchair is allowed by Medicaid.

B. Replacement Parts for a Wheelchair

Replacement parts for a wheelchair, such as tires or wheels, must be prior authorized and medically necessary. These repairs or replacements cannot be approved more frequently than once per year.

C. Wheelchair for a Resident of a Long Term Care Facility

Wheelchairs and accessories are covered for a resident of a long term care facility as part of the per diem rate. A long term care facility is responsible to provide wheelchairs for its residents, including wheelchairs adapted to the shape and physical needs of the resident using stock parts or attachments assembled by the manufacture or the vendor. Medicaid does not consider these to be 'customized wheelchairs'. Medicaid is responsible for medically necessary customized wheelchairs which require a special manufactured frame, such as a tilt-in-space or hemi wheelchair."

Additional accessories or attachments which are uniquely shaped or formed, such as a contour back or seat, for the client and can not be reused by other clients may be authorized by Medicaid and must meet the criteria for customized wheelchairs. Refer to item G, Customized Wheelchairs.

If a wheelchair is approved for a resident of a nursing facility, and the client leaves the facility, the client may take the wheelchair with him or her. Wheel chairs provided by the facility for the client remain the property of the facility. Motorized wheel chairs are covered if the criterion are met. Refer to item H, Motorized Wheelchairs.

Repairs to a wheelchair owned by a long term care facility are the responsibility of the facility. Alternately, a long term care facility may provide another suitable wheelchair if the physician has written "wheelchair bound" in the patient chart.

D. Replacement Batteries

Replacement batteries are covered, including for a resident of a long term care facility. Battery chargers are not covered.

E. Wheelchair Warranty

All wheelchairs must carry the maximum, most cost-effective warranty available as part of the purchase price.

F. Standard Wheelchairs

1. **Definition:** A standard wheelchair is one that generally satisfies the needs of the average-size patient, is fabricated to withstand normal usage and body weight, and has brakes and armrests. A standard wheel chair includes any stock frame and stock component parts or attachments assembled to fit the patient needs which can be reused and reconfigured for another patient. Refer to the Medical Supplies List for codes.

   A youth chair is considered a standard wheelchair. All standard limitations apply to youth chairs.

2. **Criteria for Medicaid Client to Qualify for a Standard Wheelchair**

   A Medicaid client must meet the criteria listed below to qualify for a standard wheelchair

   a. The client's condition must be such that, without the use of a wheelchair, the patient would be confined to bed or chair without functional ambulation. An individual may qualify for a wheelchair and still be considered bed confined.

      A wheelchair may be approved if it allows a client to become more independent, or maintain independence, within his or her living environment as documented.

   b. The client is not a resident of an ICF/MR (intermediate care facility) or a nursing facility. A standard wheelchair is not a benefit for a resident in an ICFMR or in a nursing facility.

   c. A standard wheelchair is not a benefit for a resident of a nursing facility. Standard wheel chairs and attachments are provided by the facility through the per diem rate paid to the facility.

3. **Documentation Requirements for a Standard Wheelchair**
   a. Documentation submitted must be current.
   b. The Prior Approval Request Form must include the code and all relevant information.
   c. Physician's order for the wheelchair.
   d. A letter of medical need from the physician. The letter must include a detailed systems review of the client with the following information:
      (1) Medical diagnosis and prognosis; and
      (2) Medical reasons for wheelchair.

4. **Reimbursement**

   a. All wheel chairs must be described in writing and identified by a HCPCS code.
   b. All accessories and attachments added to a wheelchair costing more than $10.00 each, must be described in writing and identified by the proper HCPCS code.
   c. Reimbursement is by HCPCS code.

G. Customized Wheelchairs

1. Definition

A customized manual wheelchair is one which has been uniquely constructed or substantially modified for a specific client. The assembly of a wheelchair from modular components does not meet the requirements of a customized wheelchair. The use of customized options or accessories does not result in the wheelchair base being considered as custom. There must be customization of the frame for the wheelchair to be considered customized. This wheel chair type is for patients living at home.

A physical therapist or an occupational therapist and medical supplier representative may be involved the selection and fitting of a customized wheel chair. A similar evaluation as in customized wheel chairs may be performed by a physical therapist.

2. Criteria for Medicaid Clients to Qualify for a Customized Wheelchair for Use in the Home

A customized wheelchair must be medically necessary and customized for a Medicaid client to allow him or her to become more independent or maintain independence within his or her living environment. A chair to better sports rating, outdoor participation, is not covered.

A Medicaid client must meet all of the following criteria to qualify for a customized wheelchair.

a. Be non-ambulatory (ability to walk only a few steps is considered non-ambulatory) or have a prognosis of not being able to ambulate within the next 12 months.

b. Require a mobility aid to participate in normal daily activities in the home.

c. Expect to have physical improvements, or the reduction of the possibility of further physical deterioration, from the use of a customized wheelchair; OR be for the necessary treatment of a medical condition..

d. The client or primary care giver must be capable of maintaining the wheelchair or be capable of causing the wheelchair to be repaired and maintained.

e. Repairs for a customized wheelchair require prior authorization

* f. Must not currently own a medically appropriate type of chair for which reimbursement is being sought by Medicaid **or** must not have received a Medicaid reimbursed customized or motorized wheelchair within the previous five year period.

g. Due to the federal requirements relating to non-duplication of services, a client who requires a customized or motorized wheelchair for continued employment, or a client who has a reasonable expectation for vocational development, must be referred to the Office of Rehabilitation Services in the Department of Education for an evaluation of eligibility for vocational rehabilitation services. Either the physician or the PT/OT may make the referral to Rehabilitation Services.

3. **Documentation Requirements for a Customized Wheelchair**

   a. Documentation submitted must be current.

   b. The Prior Approval Request Form must include the Medicaid codes for the wheelchair and Medicaid code for each attachment with all relevant information. An evaluation by a physical therapist may be performed as noted in item I, Evaluation for Customized and Motorized Wheelchairs.

   c. Physician's order for the wheelchair.

   d. A letter of medical need from the physician. The letter must include a detailed systems review of the client with the following information:

      (1) Medical diagnosis and prognosis; and

      (2) Medical reasons for wheelchair.

   e. All customized wheel chairs must be described in writing and identified by a HCPCS code.

   f. All accessories and attachments added to a wheelchair and costing more than $25.00 each must be described in writing and identified by the proper HCPCS code.

4. **Attachments for Customized Wheelchair**

   a. The vendor must keep all physician requests for separate attachments on file. All attachments require prior authorization to prevent the addition of attachments which have not been prior authorized to a wheelchair which has been authorized.

   b. Attachment codes are available to replace a part, repair a chair, etc., but require prior authorization.

   c. All current wheelchair codes will remain available for lease, rental or purchase as is, or attachment of one or two items.

5. **Reimbursement**

   a. All wheel chairs must be described in writing and identified by a HCPCS code.

   b. All accessories and attachments added to a wheelchair and costing more than $10.00 each must be described in writing and identified by the proper HCPCS code.

   c. Reimbursement is by HCPCS codes.

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   d. When the approved Prior Authorization is returned to the provider/vendor, and the chair is delivered, bill Medicaid for the chair and all attachments. The medical supplier cannot bill until the subsequent evaluation is completed by the PT/OT. Refer to item I, Evaluation for a Customized or Motorized Wheelchair.

H. Motorized Wheelchairs

A physician, a medical supplier, a physical therapist/occupational therapist, the long term care facility facility if the patient is a resident of a long term care facility, and Medicaid Prior Authorization staff must be involved to obtain a motorized wheelchair for a Medicaid client. Motorized wheelchairs are for use within the home or residence.

1. Criteria for a Motorized Wheel Chair

To qualify for a motorized electric wheelchair, a client must meet all the criteria for a customized wheel chair and the additional criteria listed below:

*

a. Have a poor prognosis for ever being able to self-propel a functional distance.

b. Manifest the cognitive and physical ability necessary to operate a power driven wheelchair.

c. Demonstrate the ability to safely operate a power driven chair. A client of any age should have had a minimum of two hours instructions and use in an electric wheelchair. The physician and therapist documentation must indicate the patient's cognitive ability to operate the power chair. The patient must be able to manifest the physical, visual and mental ability to safely operate a wheelchair.

d. The demonstrated medical necessity must be for use within the home or facility of residence.

e. The client and primary care giver(s) should have accepted or agree to accept education and training by a therapist to assist in adopting an attitude and fostering the expectation that the client will be allowed to be as independent as physically able.

2. Documentation Requirements for a Motorized Wheelchair

The medical supplier must complete the Medicaid Prior Approval Form and provide the documentation listed below with the request. Documentation submitted must be current.

a. Price list showing the catalog price of the base wheelchair, related components, and all attachments. Customized changes not specified in the catalog must be described on a separate form.

b. Physician's order for the motorized wheelchair.

c. A letter of medical need from the physician. The letter must include a detailed systems review of the client with the following information:

(1) Medical diagnosis and prognosis;

(2) Medical reasons for a motorized wheelchair; and

(3) The type of chair and attachments required by the client.

d. An initial wheelchair evaluation from a registered physical therapist/occupational therapist (PT/OT). Refer to item I, Evaluation for a Customized or Motorized Wheelchair.

e. Copies of all warranties relating to the wheelchair. All wheelchairs must carry the maximum, most cost-effective warranty available.

3. Motorized Wheelchair Billing

When the approved Prior Authorization is returned to the provider/vendor and the chair is delivered, bill Medicaid for the chair and all attachments. The medical supplier cannot bill until the subsequent evaluation is completed by the PT/OT. Refer to item I, Evaluation for a Customized or Motorized Wheelchair.

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4. Reimbursement

Motorized wheelchairs, are manually priced at the manufacturer's published catalog price less 20%. Component parts costing less than $20.00 and the related labor costs are covered by operating margins.

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I. Evaluation for a Customized or Motorized Wheelchair

A registered, licensed physical therapist/occupational therapist (PT/OT) must complete both an initial wheelchair evaluation and a subsequent evaluation.

1. Initial Evaluation

   The initial evaluation should be done at the time the client's measurements are taken and the wheelchair dimensions are assessed. For clients age 21 and older, an initial evaluation must have been done within the last *six* months. For clients from birth through age 20, an initial evaluation must have been done within the last *three* months.

   The evaluation must include the following:

   a. Age, height, weight of the client;

   b. The treatment and goals of therapy intervention, if applicable;

   c. Specific level of involvement;

   d. Functional limitations and abilities;

   e. Description of all disabilities and deformities;

   f. Custom features needed by the client and the medical benefit that each feature provides for his or her medical needs;

   g. Information regarding the client's previous wheelchair history, including whether or not the patient has a medically appropriate chair purchased by Medicaid within the previous 5 years;

   h. Information regarding the patient's ability to learn the skills needed to operate the chair safely, especially if the client is under age 21. A child *must have had* a minimum of two hours instructions and use in an electric wheelchair.

      The therapist will document on the *"Electric Wheelchair Checklist"* that the client can perform the necessary skills. A copy of the checklist is included with this manual. Submit this checklist to the Division of Health Care Financing, Utilization Management Unit, with the required documentation.

   i. Education and training of the client and primary care givers by a trained therapist to assist in adopting an attitude and fostering the expectation that the client will be allowed to be as independent as physically able. The purpose is to prevent learned helplessness and passive resignation.

   j. An assessment of the ability of the client or primary care giver for reasonable maintenance and repair, or to cause such maintenance and repair;

   k. Why the client's needs cannot be met with a standard Medicaid reimbursable wheelchair;

l. For residents in a nursing facility, the documentation must describe in detail how the request for a customized chair is supported by the Resident Assessment Process of the client and the goals of the client's care plan.

m. A video tape of the patient in an electric wheelchair may be submitted to Medicaid prior authorization with the initial request for prior authorization prior authorization. If not submitted, Medicaid may request a video tape any time the need to clarify the need for an electric wheelchair arises.

2. **Subsequent Evaluation for a Customized or Motorized Wheelchair**

Subsequent to the approval for a customized or motorized wheelchair, the PT/OT should conduct another evaluation. Customized wheelchairs REQUIRE a post evaluation before the provider will be reimbursed. The evaluation includes the initial phase to determine what the patient needs and the final phase to determine if the chair received is appropriate for the patient needs.

The subsequent evaluation is required to determine the following:

a. The client is fitted properly in the wheelchair;

b. All approved attachments to the wheelchair were in fact received by the client and are appropriate to meet his or her medical needs and;

c. When the wheelchair is motorized, the client has successfully completed, or demonstrates the potential to learn, the requirements of the electric wheelchair training progression. A copy of the electric wheelchair training checklist is included with this manual.

d. If the chair is then approved, a final evaluation is sent to the Division of Health Care Financing, Utilization Management Unit. If additional attachments or modifications were needed, attach the manufacturer's suggested retail price list as well.

e. The final evaluation must be sent to the Medicaid prior authorization unit, with additions if necessary, for pricing.

f. The wheelchair will be priced and the supplier notified when prior approval is given, but payment will NOT be made until after the final evaluation.

g. The final evaluation must certify that the wheelchair fits properly and that any attachments required are present and appropriate.

J. Modifications and Repairs to Wheelchairs

Prior authorization is required for all modifications, such as upgrades and attachments, and repairs. Clients who own a motorized or customized wheelchair may obtain medically necessary modifications under the following conditions:

1. Modifications must be medically necessary.

   For example, a tray may be approved for support of the body when trunk involvement requires it, but not for a table, books, or toys. Pneumatic tires or balloon tires on wheelchairs may be approved when the medical condition of the client is such that the tires are necessary in his or her residence.

   Modifications are NOT reimbursable if the planned use is primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort.

   Reupholstering the chair is not a Medicaid benefit for five years from the time of the original approval for the wheelchair.

   As a part of any request for a custom seating system, documentation must include the client's disabilities, as well as the medical benefits expected.

   Medically required, specially designed seating systems must be planned, with the best efforts of all parties, to accommodate the client for a minimum of five (5) years.

2. All repairs must have prior authorization. Medicaid will authorize needed repairs and replacement parts only once in every twelve (12) months.

   Repairs do not include routine maintenance, such as changing tires, inspecting the chair, changing batteries, grease and oil, etc. Repairs while the chair is under warranty are not covered. Repairs for a rental chair are not covered. Reupholstery may be approved when the warranty has expired and the original upholstery is beyond repair.

K. Replacement of Wheelchairs

Any replacement of a wheelchair purchased by Medicaid must have prior authorization. Wheelchairs are not replaced by Medicaid for five years after initial purchase. If a wheelchair is stolen, the medical provider requesting a new wheelchair should obtain a copy of the police report. The medical provider must either document on the prior authorization request that a copy has been obtained or send a copy with the request. Medicaid will not consider authorization until two months after the filing of the police report to ensure adequate time for possible recovery of the wheelchair. If the chair is necessary for the client to maintain employment, or independence, Medicaid will consider a short-term rental chair for a period not to exceed 120 days.

Medicaid will cover repairs for only one wheelchair which will generally be the most recent wheelchair provided by Medicaid to the client.

L. Pricing of Customized Wheelchair

Customized wheelchairs, including electric wheelchairs, are manually priced. Customized wheelchairs that are not electric are priced at the manufacturer's published catalog price less 25%. Customized wheelchairs that are electric are priced at the manufacturer's published catalog price less 20%. Component parts costing less than $25.00 and the related labor costs are covered by operating margins. All components used to customize a wheelchair costing more than $25.00 each, must be (1) described in writing, (2) priced using manufacturer's list and (3) have been prior authorized by Medicaid.

M. Attachments for Customized Wheelchair

1. All physician requests for separate attachments will remain on file with the vendor. All attachments require prior authorization to prevent the addition of attachments which have not been prior authorized to a wheelchair which has been authorized.

2. Attachment codes are available to replace a part, repair a chair, etc., but require prior authorization.

3. All old wheelchair codes will remain available for lease, rental or purchase as is, or attachment of one or two items.

N. Reimbursement for Pre-wheelchair assessment to PT/OT providers

Wheelchair assessments by PT/OT providers to determine the seating and other medically necessary requirements to the client are reimbursed $200 using code G9012, Other case management services not specified.

This page reserved for future use.

3 LIMITATIONS

The maximum quantity for medical supplies and equipment is indicated on the Medical Supplies List in the column titled 'COMMENTS & LIMITS'. If there is a need to exceed the stated limit, the medical supplier may request prior authorization. After prior authorization is obtained, the limit may be exceeded only as per the prior authorization received. If the limit is exceeded without prior authorization, the payment is subject to appropriate recovery action.

Medicaid will not reimburse providers for duplication of hospital equipment in a home or long term care facility. Medicaid is required to obtain the most cost effective service appropriate for the patient. For some patients, a long term care facility may be the most appropriate and cost effective setting.

Specific Limitations

1. When disposable underpads are limited to 156 a month or less, no prior authorization is necessary. When the monthly quantity exceeds 156 a month, prior authorization and documentation of medical need is required.

2. Surgical stockings are limited to two pair every six months when medically necessary.

3. Wheelchair attachments must be placed on a standard wheelchair unless documentation justifies otherwise.

4. Pneumatic tires or balloon tires on wheelchairs are not a benefit unless documented (with a prior approval) that the medical condition of the patient is such that the tires are necessary in the residence as well as outside.

5. Sacro-lumbar or dorsal lumbar corset type supplies are NOT considered prosthetic devices or special appliances. These items are not a covered benefit of the Medicaid program.

4 PURCHASE OR RENTAL OF EQUIPMENT

Most medical supplies are available for purchase. The Medical Supplies List indicates items which are available only for lease or rental, capped rental, purchase or rental. All other supplies are purchase only. Examples of the coding are found on page 2 of the Medical Supplies List.

1. Medical supplies purchased under the Medicaid program must be new, unused equipment. Payment is for new equipment, and the medical supplier must be able to furnish invoices showing that the equipment is new. Refurbished, rebuilt, or used equipment is not acceptable for purchase by Medicaid, unless specifically authorized in writing for an individual piece of equipment or unless specifically allowed under contract with the Division of Health Care Financing

2. Certain durable medical equipment may be paid as a lease/rental for twelve months only. Other durable medical equipment may be paid as capped rental for twelve months only. After twelve months, Medicaid considers the equipment to be paid in full and owned by the patient. Equipment which may be owned by the patient after Medicaid has paid the capped rental for twelve months includes but is not limited to the following items: beds, wheelchairs, vaporizers, nebulizers

3. Rental of DME: Certain highly specialized equipment is so technical and costly to maintain that it is fiscally more responsible to furnish the equipment to a client on a permanent rental basis. This rental will include maintenance and back-up equipment if needed. This type of rental DME will have an RR modifier associated with the code. Such equipment includes but is not limited to ventilators and oxygen concentrators.

4. Other rental DME may be capped and converted to a purchase after 12 months. These codes will have the modifier LL associated with the code. Some capped DME require maintenance and service may use the “ms” modifier once every six months, beginning six months after the rental has converted to a purchase and all rental charges have been billed for reimbursement for maintenance and service required to maintain the device. This may be billed using the HCPCs code with the LL modifier and adding the “ms” modifier as a second modifier on the HCFA 1500 form. The reimbursement for the “ms” modifier will be equal to one monthly rental fee. A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use cease in order for a new 12-month rental period to begin. A prior is not required using the “ms” modifier.

   The maintenance and service fee is for maintenance and service on the DME as needed to keep the equipment operating properly and includes all supplies, service and maintenance which are routinely supplied when the item was being provided as a monthly rental.

*

5 SUPPLIES FOR PATIENTS IN A LONG TERM CARE and ICF-MR FACILITY

Medicaid pays a per diem rate under contract with long term care and ICF-MR facilities to provide room, dietary services, routine services, medical supplies and equipment. Under the contract, the facility must provide certain routine items, even though they may be considered ancillary by the facility. Medical supplies and equipment covered in the Medicaid contract are not reimbursable for residents of a long term care facility.

On the Medical Supplies List, a column titled 'LTC' (long term care facility) indicates which items are reimbursable for a Medicaid client who resides in a long term care facility or ICF-MR. **Only items marked 'Y' meaning 'YES' may be reimbursed when the client resides in a long term care facility.**

A. The supplies and equipment in the following list may **not** be billed independently to Medicaid for persons residing in a long term care or ICF-MR facility, **nor may these items be billed to the Medicaid client by either the facility or the medical supplier.**

1. Items furnished routinely and relatively uniformly to all patients, such as patient gown, water pitchers, basins and bedpans.

2. Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such alcohol, applicators, cotton balls, Band-Aids, suppositories and tongue depressors.

3. Items used by individual patients, but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, customized wheelchairs, traction equipment and other durable medical equipment.

4. All other medical supplies and non-prescription pharmacy items normally provided by a long term care facility, including but are not limited to:
   a. Syringes
   b. Ostomy supplies
   c. Irrigation equipment and material for irrigation
   d. Dressings, except decubitus dressings at the present time
   e. Catheters: urinary, I.V., trachea
   f. Elastic stockings
   g. Test tape
   h. I.V. set up, tubing, clamps, catheters, dressings
   i. Colostomy bags
   j. Cervical collars
   k. Prosthetic and stump socks except for prosthetic shrinkers
   l. Nutritional supplements
   m. IBBP machines
   n. Equipment for administering oxygen
   o. Oxygen systems, with the exception of oxygen concentrators
   p. Ventilator equipment
   q. Wheelchairs, accessories, attachments, batteries and repairs. However, electric wheelchairs and repairs to power or special wheelchairs may be covered by Medicaid under special circumstances.
   r. Diapers

B. Items **not covered by the per diem and considered non-routine** under the contract with the long term care facility or ICF-MR are considered ancillary services. Such items include prescription drugs (legend drugs), antacids, insulin, total nutrition (parenteral or enteral diet given through gastrostomy, jejunostomy, I. V. or stomach tube), antilipemic agents, hepatic agents, and high nitrogen agents. Ancillary items must be billed by the supplier, usually a pharmacy, directly to Medicaid. Non-routine items may not be billed by the facility.

6 PRIOR AUTHORIZATION

Certain medical supplies and equipment require prior authorization (PA) **before** the medical supply is dispensed or service is given in order to be reimbursable. The PA requirement is noted in policy and on the Medical Supplies List. Refer to page 2 of the Medical Supplies List for coding information. PA criteria are also described both in policy and itemized on the list.

For more information about the prior authorization process and the Child Health Evaluation and Care (CHEC) Program, refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 9, Prior Authorization Process, and to the Utah Medicaid Provider Manual for CHEC Services. These are available on the Internet at:
SECTION 1: http://health.utah.gov/medicaid/pdfs/SECTION1.pdf
The on-line CHEC Manual is on a list at http://health.utah.gov/medicaid/pdfs/section2list.pdf

1. Prior authorization to provide services beyond the designated limitations or not appearing on the Medical Supplies List must be requested in writing in advance of the date of service. Verification will be provided by the Division of Health Care Financing. Prior authorization is also necessary for items not listed on the index.

2. All data elements on the Prior Authorization Request Form must be completed. Refer to the instructions for completion of the form in the General Attachments Section of this manual.

3. Documentation must be complete and extensive enough to justify the service or supply.

4. If a quantity is requested that exceeds the quantity listed in the index, the exact total quantity must be present.

5. Requests for rental must specify the length of time the item is to be used.

6. All oxygen requires a prior authorization. The rate of oxygen flow and the hours per day must be specified on the physician's order, and a copy of the order must be retained on file with the Request for Prior Authorization.

7. When the prior authorization request is approved and a copy returned to the provider signed and dated with implementation and termination dates, service or supplies may be provided.

8. When the documentation is not complete, the necessary information required will be identified and the requestor will be notified.

9. When the prior authorization is denied,
   a. the provider will be informed via telephone or letter.
   b. any further action will depend upon the nature of the denial.

10. All durable medical equipment requires prior authorization, even in situations where a third party pays the provider the major part of the cost. For billing instructions, refer to SECTION 1, Chapter 11 - 4, Billing Third Parties.

11. Prior authorization for durable medical equipment, prosthetic devices, or braces will no longer be necessary for clients who have both Medicare and Medicaid benefits (crossover claims). For information on billing Medicare/Medicaid cross-over claims, refer to SECTION 1, Chapter 11 -6.

Retroactive Authorization

Retroactive authorization is authorization given after service is given. Retroactive authorization will NOT be given except in either of the two circumstances in item 1 below and then only for the services listed in item 2.

1. Circumstances under which retroactive authorization may be given:

   A. Retroactive Medicaid Eligibility
   When a Medicaid client becomes eligible retroactively for Medicaid and has already received medical supplies and equipment which require Prior authorization, Medicaid may allow a prepayment review for supplies and equipment dispensed, rather than denying reimbursement solely because prior authorization was not obtained.

   B. Medical Emergency
   Medical supplies and equipment listed in item 2 and provided in a medical emergency may be considered for retroactive authorization.

2. Only the medical supplies and equipment listed below may be considered for retroactive authorization.

   - Enteral or parenteral therapy equipment
   - Enteral or parenteral nutrients
   - Hospital bed and related equipment
   - Oxygen and related respiratory equipment
   - Concentrator
   - Gaseous oxygen or liquid oxygen only when supplied to a private client who subsequently becomes Medicaid eligible
   - Ventilator and related equipment
   - Humidifier/nebulizer/pulmoaide
   - Apnea monitor

6 - 1 Written Prior Authorization

Send written requests to:

MEDICAID PRIOR AUTHORIZATION
P.O. BOX 143103
SALT LAKE CITY UT 84114-3103

Fax Number

Prior authorization requests may be faxed to
(1-801) 538-6382, attention "Prior Authorizations"

6 - 2 Telephone Prior Authorization

1. Call Medicaid Information:

   In the Salt Lake City area, call **538-6155**

   Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado **1-800-662-9651**

   From all other areas **1-801-538-6155**

2. Follow the telephone menu prompts.

7 REPAIRS and REPLACEMENT

Repair or reconstruction of appliances is a benefit of the program. Maintenance, repairs, replacement parts, and labor for **rented** medical equipment are the responsibility of the provider.

Repairs and replacement parts are a benefit when:

1. The equipment is a Medicaid-covered benefit;
2. The equipment is owned by the patient;
3. The equipment is being used by the patient in his or her home;
4. The equipment is no longer under warranty;
5. Repairs require prior authorization.
6. Documentation must demonstrate a medical need.
7. Repairs are allowed at selected intervals: wheelchairs, yearly; batteries for electric wheelchairs, yearly; mattresses at five year intervals.

Limits on Repairs

1. Repair or non-routine service (for example, sealed components) requiring the skill of a technician are limited to three units per calendar year. One hour equals one unit.
2. Document type of repair and time involved. Submit invoices with claim.
3. Only one repair per year is allowed on all DME equipment and only if medically necessary.
    a. Repairs do not include changes in upholstery, padding, or cushioning. When a repair is determined medically necessary for these items, they must be prior authorized. Include documentation attached to the request.
    b. Repairs for hearing aids are selectively approved when the repair is over $15.00.

Limit on Replacements

Durable medical equipment will not be replaced more often than once in a five year period.

8 RETURNED MEDICAL SUPPLIES

If a customer returns a medical supply or equipment purchased with a Medicaid card, a cash refund should not be given. Instead, the provider must refund the payment to Medicaid. Please call Medicaid Information about returns.

9 BILLING

Providers must accept Medicare assignment for patients who are eligible for both Medicare and Medicaid reimbursement. Medicare must be billed first using the codes found in the Medicare provider manual.

Medical supplies and equipment may be billed electronically through an electronic data exchange or on a HCFA-1500 claim form. When Medicaid requires documentation of the physician's order, the medical supplier must submit the documentation with the claim in order to receive reimbursement.

10 NON-COVERED SERVICES

No item, durable medical equipment or supply, disposable or semi-disposable, is reimbursable if the planned use is primarily for hygiene, education, exercise, convenience, cosmetic purposes, social interaction or comfort. While the Division of Health Care Financing recognizes the benefits of such uses, reimbursement is limited to items whose use is required by a medical necessity. Items needed for some other purpose should be requested through another source, such as a benevolent organization, church or civic group, etc. Examples of non-covered items include, but are not limited to, items in the list which follows. In addition, no item is reimbursable if prior authorization is required and is not obtained.

1. Equipment whose primary purpose is convenience, cosmetics, or comfort is not a benefit. Examples of items not covered include hot tubs; exercise equipment, such as bikes, treadmills, stair climbers; fitness center memberships; scooters; elevators; wheelchair lifts; 'Lifeline' monitor; purification systems; wigs; panty hose; battery chargers.

2. Modifications of durable medical equipment or supplies for reasons of convenience, cosmetics, or comfort, such as changes in upholstery, padding, cushioning, are not a benefit. Some consideration for replacement will be given if upholstery, padding or cushions are more than five years old.

3. Equipment permanently attached or mounted to a building or a vehicle is not a benefit. This includes ramps, lifts, bathroom rails.

4. Routine maintenance of equipment is not a benefit. The patient is responsible for routine maintenance and upkeep of purchased equipment.

5. Repairs are not a benefit in the following circumstances:

    a. The item is not owned by the Medicaid client or not being used by the client in his or her home.
    b. The repairs or parts are for equipment which is not a benefit.
    c. The item is under warranty.
    d. Shoe repair is not a benefit.

6. Usual household remedies such as Band-Aids, hydrogen peroxide, antiseptics, cleaning supplies, etc., are not a benefit.

7. Nutritional supplements for children are not a benefit.

8. Baby foods, such as Similac, Enfamil, Mull-Soy, etc., are not a benefit. These are considered breast milk substitutes, not medical supplies.

9. Equipment and supplies for a resident of a long term care facility which are covered under contract. Refer to Chapter 5, Patients in a Long term Care Facility.

10. Variable height beds and electric beds are not a benefit.

11. Spring loaded patient lifts are not a benefit.

12. Pneumatic tires or balloon tires on wheelchairs are not a benefit when the medical condition of the patient is such that the tires are necessary only in the patient's residence, but not outside the residence.

13. Corsets are not a benefit of the program, nor are canvas "braces" with plastic or metal "bones." This includes maternity corsets. Although some corsets have "stays" or wire supports, they are obtainable from department stores.

14. Cervical pillows are not a benefit.

15. Shoes and accessories are not a benefit. Shoes include the following:

    a. Mismatched shoes.
    b. "Comfortable" shoes following surgeries such as, but not limited to, bunionectomies.
    c. Shoes to "support" an overweight individual.
    d. Shoes used as a "bandage" following foot surgery.
    e. Trade name or brand name shoes.
    f. Arch supports, foot pads, metatarsal head appliances, or foot supports.
    g. “Slip-in” orthotics
    h. Shoe repair

16. “Off the shelf” braces are not covered.

17. Reflux boards are not covered.

18. Mail order items, such as hearing aids and vision aids.

19. Multiple oxygen systems are not a Medicaid benefit.

PEDIATRIC CUSTOMIZED AND MOTORIZED WHEELCHAIR CRITERIA: ELECTRIC WHEELCHAIR TRAINING PROGRESSION CHECKLIST

DEMONSTRATED TASK	MET	NOT MET
1. Demonstrates awareness of control unit.		
2. Able to tolerate movement.		
3. Able to release control unit to stop when given a command.		
4. Able to move chair in any direction in an open area.		
5. Tolerates hand-over-hand assistance from others.		
6. Demonstrates the ability to follow requests to go forward, left, right or stop.		
7. Demonstrates the ability to drive wheelchair in an uncrowded hallway.		
8. Learns when to use horn appropriately (when applicable) to warn others of presence.		
9. Demonstrates the ability to drive wheelchair with supervision.		
10. Demonstrates the ability to drive wheelchair between two people.		
11. Demonstrates the ability to maneuver around two people.		
12. Demonstrates the ability to drive wheelchair in and out of three cones.		
13. Demonstrates the awareness of other people in their pathway and stops chair to prevent hitting others.		
14. Demonstrates the ability to drive through door ways.		
15. Demonstrates the ability to drive up and down ramps.		
16. Demonstrates the ability to maneuver around large obstacles.		
17. Begins to recognize changes in surfaces and stops.		
18. Begins to maneuver wheelchair outside with supervision.		
19. Begins to learn the concept of backing up with cuing that the area is free of obstacles.		
20. Demonstrates the awareness of space behind and demonstrates appropriate precautions when backing up.		
21. Demonstrates the ability to turn on and off the wheelchair with indirect supervision.		
22. Demonstrates the ability to maneuver through crowded hallways with indirect supervision.		
23. Demonstrates the ability to maneuver through crowded hallways with indirect supervision.		
24. Demonstrates the ability to freely maneuver wheelchair with indirect supervision.		
25. Demonstrates the ability to access child-specific environments with indirect supervision.		
26. Demonstrates independence with wheelchair.		

PATIENT NAME_____ **DATE**_____

THERAPIST WHO OBSERVED THE TRAINING_____

MEDICAL SUPPLY VENDOR_____

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